Cigna HealthSpring SpecialCare of Illinois

Cigna HealthSpring CarePlan of Illinois
(Medicare-Medicaid Plan)

Payment Dispute Form FAQ

For Cigna-HealthSpring Medicaid or MMP Claims

Cigna-HealthSpring® SpecialCare of Illinois and Cigna-HealthSpring® CarePlan (Medicare-Medicaid Plan) of Illinois have implemented an improved way to request a payment dispute of a denied or improperly paid claim. Below you will find some of the most common questions on when to use, how to use and if you should use this form:

Question: Why would a Provider use this form?
Answer: Underpaid / Overpaid claims, authorization issues, modifier issues, claims denied as a duplicate, incorrect coding, timely filing, applied income. This form is not to be used for corrected claims, or claim appeals.

Question: What is the turnaround time?
Answer: 30 days for a standard payment dispute and 45 days for a payment dispute involving 10 or more claims.

Question: If the results are not to my satisfaction, what is the next step?
Answer: Providers may file an appeal if they do not agree with the payment dispute outcome.
How soon can I take that action? Answer: The appeal rights begin as soon as the Provider receives the Payment Dispute resolution letter.

Question: How will I get notified of the status of a payment dispute?
Answer: A resolution letter will be sent to the Provider once the payment dispute request has been completed.

Question: Am I required to use the form?
Answer: The form is not required – Cigna-HealthSpring asks that Providers clarify if they are requesting a payment dispute or an appeal. See example of details under "Payment Dispute" for required documentation without using this form.

Question: What is the maximum number of issues I can submit?
Answer: There is not a limit.

Question: If I go over the number of entries on the form, will I need to submit a second form?
Answer: Cigna-HealthSpring asks for any request that includes 10 or more claims and the claims are denied for the same issue, that a spreadsheet is submitted. This will enable us to work this through the payment dispute claims project.

Question: What is the difference between a Payment Dispute, an Appeal and a Corrected Claim, and what are the qualifying circumstances? (See all answers below)

Answer:

1. **Corrected claim** – A Provider is CHANGING the original claim.

   Corrected claims must clearly indicate they are corrected in one of the following ways:

   CMS 1500 Paper Form - By entering a "7" on box 22 as the resubmission code, followed by the original claim number in the Original Reference Number box. UB-04/CMS-1450 Paper Form – Submit with the third digit of Type of Bill, as "7" (replacement of prior claim).

   Submit a corrected paper claim to:

   1.) Cigna-HealthSpring
   Attn: Claims – Correction
   PO Box 981709
   El Paso, TX 79998-1709

   2.) Electronically (Payer ID# 52192): Via your claims clearinghouses.

Timely Filling Policy: 180 days of the original claim received date on the CHS explanation of payment (EOP).

2. **Payment Dispute**– Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)

   A request for Payment Dispute is a written communication from the Provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records. CHS Payment Dispute Form can be completed but it's not required. If you choose not to use, we do ask that Providers clarify if they are requesting a payment dispute or an appeal.

   The documentation must also include a description of the reason for the request.
   a. Indicate "Payment dispute" of (original claim number)"
   b. Include a copy of the original Explanation of Payment
   c. Please note that unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.

   The "Request for a Payment Dispute" should be sent to:
   Fax: 1-877-809-0783
   Email: Claims_MMP_Medicaid@HealthSpring.com
   Mail: Cigna-HealthSpring
   Attention: Payment Dispute Unit
   P.O. Box 211088
   Bedford, TX 76095

Timely Filling Policy: 120 days for Medicaid plans (ICP) and 60 days for Medicare-Medicaid Plans (MMP); from the date of the CHS Explanation of Payment (EOP).

3. **Appeal** – Provider disagrees with the outcome of the request for Payment Dispute.

   An appealed claim is a claim that has been previously adjudicated as a Clean Claim and the provider is appealing the disposition through written notification. Also, if you received an unsatisfactory response to a request for a Payment Dispute that has been previously submitted.

   To expedite processing of the Appeal, please include the original request for payment dispute letter and the response.

   Appeal request and supporting documentation should be sent to:
   Cigna-HealthSpring
   Attention: Appeal and Grievance Department
   P.O. Box 211088
   Bedford, TX 76095

Timely Filling Policy: 60 days from the date of the CHS explanation of payment (EOP)

If the corrected claim, the request for payment dispute or the claim appeal, results in an adjusted claim, the Provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the Provider will receive a revised EOP or letter detailing the decision and steps for escalated payment dispute.

CHS processes and finalizes all corrected claims, requests for payment disputes and appeals to a paid or denied status in accordance with state law and regulation.

1.) For claims that are partially paid or denied, please re-submit this form with supporting documents.
   a. Copy of the Explanation of Payment (EOP)
   b. Copy of the Original Invoice (if applicable)
   c. Other requesting documents

2.) To send completed Payment Dispute Form, please fax to 1-877-809-0783, e-mail to Claims_MMP_Medicaid@HealthSpring.com or mail to:
   Attention: Cigna-HealthSpring Payment Dispute Unit
   P.O. BOX 211088
   Bedford, TX 76095

NOTE: All requests for corrected claims, payment disputes or appeals must be received within the timely filing policy. Prior processing will be upheld if received outside of the timely filing, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. **For any questions, please contact Provider Services at: 1-866-486-6065.**